

FAMILY CHILDCARE PROVIDER CHILD ENROLLMENT PACKET



Family Childcare Provider _____

Date of Enrollment _____

Child's Name _____

Parent(s) Name _____

Parent Responsibility

Please read the Information to Parents brochure

Family child care providers are not babysitters. They are educators of children in a home setting.

Family child care is a business and each provider has mandatory programs requirements in which your corporation is needed.

As in any educational setting, there are rules and regulations. Finally, child care providers must maintain the registration requirements as per the Manual of Requirements for Family Child Care Registration.

The manual specifies that each provider must maintain records for each child in their care.

As a parent that has contracted with a registered provider for child care services, you are required to submit contract information as well as health information for your child.

The attached forms are required to be completed by each parent that has a child enrolled in a registered family child care provider home.

Though it is a home setting, the state rules and regulations must be followed to ensure the health, safety and well-being of children.

In order for providers to maintain their registration and avoid violations which can jeopardize their child care business, parents are required to complete the attached forms before their child begins care or within **30** days of enrolling their child in a family child care program. Sometimes there is a delay in getting appointments with physicians but a delay in submitting the forms affects the provider's registration.

It is recommended that parents complete and submit the forms at the beginning of child care services to ensure that the provider has accurate information to contract parents in case of emergency and are aware of the health of a child to protect your child, other children in care as well as the provider and his/her family.

Providers that receive violations due to non-parental corporation can lose their registration which can jeopardize their child care business.

We ask for your full corporation to assist your provider in maintaining correct information for your child by completing the attached forms and returning to your provider as soon as possible.

Physicals and immunizations are mandatory for all children. Please make every effort to have your child receive a physical and receive the required immunizations.

THANK YOU FOR YOUR CORPORATION.

**PARENT'S SIGNATURE FORM
FOR RECEIPT OF INFORMATION TO
PARENTS STATEMENT**

NAME OF PROVIDER:

I have received a copy of the Information to Parents Statement from my family day care provider.

Name of Child	Parent's Signature	Date

Discipline Statement

Dear Parent:

I work with parents/guardians of children in my care to determine the cause of misbehavior and deal with behavior positively.

I use strategies that allow the child to take responsibility for his/her actions. In addition, I focus on teaching children appropriate behavior. I do not use threats or bribes; however, I do use Time Out when I feel the child needs a break away from the group. I focus on teaching children how to interact socially and continually reinforce the limits in my home. Physical punishment will not be used, even if requested by the parent.

I expect children in my care to respect others, respect the environment and respect themselves. Hitting kicking, spitting, biting, hostile verbal behavior and other behaviors, which will hurt another child, are not permitted.

Each child will be dealt with individually. Consequences will occur immediately after the behavior. As a parent, I ask you not to punish your child at home for misbehavior shown while in my care.

Please trust that I will handle the matter at my home. Furthermore, I will not discipline your child for an accident, which happened anywhere other than the daycare home.

If your child continually misbehaves, I will call you and discuss the difficulty by phone or make an appointment to discuss the difficulty with you. I will not discuss the problems in front of your child, other children or other parents.

I will keep you informed of all happenings that we are involved in at home. If I am experiencing behavior difficulties with your child, I will let you know as soon as possible. I hope that together we can create a behavior management strategy, which will control the behavior.

In those instances, when a behavior is very disruptive or harmful to the child or other children, I will discuss the issue with you. If an intervention can be made and will warrant success, the child can remain enrolled. If you will not seek appropriate assistance or we cannot effectively meet the needs of your child, you will be asked to make other childcare arrangements. I will assist you to the best of my ability to help you find other arrangements. Thank you in advance for your assistance!

(Your Name) Family Childcare Provider

(Parent(s) Signature)

(Parents(s) Signature)

Family Day Care Contract (Parent and Provider Agreement)

Please read over this contract. Sign, date and return this copy to the provider. The provider will keep this contract on file and you will receive a copy of this signed contract.

This is legal and binding contract in which if payment not received, provider can file a claim in Small Claims Court

Date of Contract _____ Full Contract Effective _____ until _____ (yearly renewal)

1st Child's Name _____ Sex _____ Birthdate ____/____/____ Age ____

2nd Child's Name _____ Sex _____ Birthdate ____/____/____ Age ____

3rd Child's Name _____ Sex _____ Birthdate ____/____/____ Age ____

Child's Home Address _____ City _____ State _____ Zip _____

Child's Home Phone # _____ Child lives with _____

Mother/Father or Guardian's Name _____ Marital Status _____

Please list all members of the child's household including ages of siblings _____

EMERGENCY INFORMATION

In the event that a parent cannot be contacted, please list two people who can be notified in the case of an emergency.

Name _____ Phone _____ Relationship to child _____

Name _____ Phone _____ Relationship to child _____

Please list all people who can pick child up from care without written consent from parents.

1. _____ 2. _____

2. _____ 4. _____

CHILD CARE HOURS and FEES

Hours contracted for care will be from _____ to _____ on the following days:

Mon. Tues. Wed. Thur. Fri. Sat. Sun

It is important that arrival and departure times are punctual and brief so that we can all get settled and proceed with our activities. If you need care beyond the contracted hours, you will need to prearrange this with the provider. The provider is under no obligation to provide an extension of time if such extension conflicts with the provider's own plan. **Late arrival** does not justify late departure.

Fees: The basic charge will be \$ _____ per _____ for full time/part-time care. And shall be paid each _____. If your child will not be in care on the date of payment you will need to drop payment off prior to Monday morning. Do not put me in a position to ask for the check—please remember to bring it.

One time registration fee: \$ _____

Late Fees: a one-time fee of \$ _____ will be charged for any late payments. Childcare will not be provided for clients with outstanding fees. Childcare will be reinstated when payment and late fees are paid in full.

Non-sufficient Fund: \$40 will be charged for any NSF checks.

Overtime fees: Overtime is considered any time outside the agreed upon interval of time. The following charges will be assessed for overtime incurred, payable upon arrival to pick-up the child:

\$ _____ per hour for prearranged overtime.

\$ _____ per 15-minute increment or portion thereof starting with the first minute in cases where overtime is not prearranged.

TRANSPORTATION

This signed contract gives the provider permission to transport by car or stroller or walk said child/ren to the following locations off the premises. The parent will always be notified of an outing before it takes place. All children under _____ will be in regulation care seats for their age and weight and all other children will wear seat belts.

1. Walk around the neighborhood 2. _____ 3. _____ 4. _____

TERMINATION /TRIAL PERIOD

Either party with two weeks' notice may terminate this contract. Both parties reserve the right to terminate without notice if the other party is in substantial violation of the agreement and/or safety or health of children is endangered.

AGREEMENT

I/we have read the contract and will comply with all the provisions contained therein. At this time, I/we shall enter into contract with _____ for care of above named child/ren with the understanding that we shall work together on the behalf of the child/ren.

This contract is in effect until a change is mutually agreed upon in writing or upon termination of care. Both parties agree to cooperate and work together on behalf of the child and accept this agreement as a binding contract.

This contract is subject to review and renewal on _____. Any changes made by the provider to the terms of the contract must be made on the renewal date unless mutually agreed to beforehand by the provider and parents or guardians who are parties to this contract. Otherwise, this contract will remain in effect until the renewal date or upon termination of care as set forth herein.

Mother Signature _____ Date _____

Legal Address of mother _____ City _____ State _____ Zip _____

Father Signature _____ Date _____

Legal Address of father _____ City _____ State _____ Zip _____

I have discussed and reviewed this contract and agree to provide care for the above-indicated child/ren, to be placed in my home as long as the terms of this contract are upheld.

Provider Signature _____ Date _____

Legal Address of provider _____ City _____ State _____ Zip _____

Contract Terminated on _____ Reason for termination _____

**CHILD INFORMATION CARD
TARJETA DE INFORMACION
DEL NIÑO**

4s of Passaic County, Inc.

Date of Admission _____ Fecha de Entrada _____	Date of Withdrawal _____ Fecha de Salida _____
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Child's Name Nombre del Niño		D.O.B Fecha de Nacimiento
Address Dirección	City Ciudad	Zip Zona Postal
Parents Name Nombre de los Padres		Telephone teléfono
Address Dirección	City Ciudad	Zip Zona Postal
1. Parent's Employer Lugar de Trabajo		Telephone teléfono
Address Dirección	City Ciudad	Zip Zona Postal
2. Parent's Employer Lugar de Trabajo		Telephone teléfono
Address Dirección	City Ciudad	Zip Zona Postal
Person to be Notified in Emergency when Parents is not Avilable /En caso de emergencia y ausencia de los Padres LLamaa		
1. Name Nombre		Telephone Teléfono
Address Dirección	City Ciudad	Zip Zona Postal
2. Name Nombre		Telephone Teléfono
Address Dirección	City Ciudad	Zip Zona Postal
Names of Persons other than parent to whom child may be released Personas que pueden recoger al Niño Ademas de los Padres		
1.	2.	3.
Name of Child's Physician Doctor del Niño		Telephone Teléfono
Address Dirección	City Ciudad	Zip Zona Postal
Child's Allergies to Drugs or Medications Niño alergico a estas Medicinas		
Parents Hospitalization Plan Seguro Medico		Policy Number Numero de póliza

I hereby give my permission to _____
Por la presente autorizo a _____ (Child Care Provider) _____ (Nombre de la Provedora)

To secure emergency medical treatment for the above named child while in my care. A buscar tratamiento medico para mi niño (a) en caso de emergencia.

Signature of Parents/ Firma de los Padres

Date/Fecha

IMMUNIZATION EXEMPTIONS

Sample Medical Contraindication Form

If an immunization is contraindicated for medical reason, this form should be completed by the child's health Care provider. It must be kept as part of the child's permanent immunization file. The medical contraindication must state both the reason and the length of the medical contraindication, and be signed by a physician licensed to practice medicine or osteopathy in any jurisdiction in the United States.

Name of Child (Last, First, M.I.)	Date of Birth (Mo/Day/Yr)	Sex Male _____	Female _____
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The following immunizations are medically contraindicated and constitute a threat to the child's health:

ANTIGENS: _____

Reason for exemption: _____

This exemption shall continue until: _____

<u>Print Name & Address of Physician</u>	<u>Telephone</u>
<u>Signature</u>	<u>Date</u>

SAMPLE RELIGIOUS EXEMPTION FORM

If a religious is claimed for a child, this form should be completed and signed by the parent or guardian. It should be kept as part of the child's permanent immunization file.

Name of Child (Last, First, M.I.)	Date of Birth (Mo/Day/Yr)	Sex Male _____	Female _____
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I request that immunizations for my child be waived on the grounds that they would interfere with the free exercise of his/her religious rights.

Name of Child (Last, First, M.I.)	Date of Birth (Mo/Day/Yr)	Sex Male _____	Female _____
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This exemption may be suspended by the State Commissioner of Health during the existence of an outbreak as determined by the Commissioner.

EMERGENCY MEDICAL AUTHORIZATION

I, _____ parent/guardian of _____,

Date of birth _____, do hereby give permission to, **Family Childcare**

Provider _____, to secure and authorize such emergency medical care and/or treatment as

above-named child might require while under the supervision of said Childcare Provider. I further authorize said

childcare provider to administer emergency care/treatment as required, until medical assistance is available, I also agree to pay all costs and fees contingent of any emergency medical care and/or treatment for said child as secured or authorized under this consent.

Note: Every effort will be made to notify parents immediately in case of emergency.

In the event of an emergency, it will be necessary to have the following information:

Child's Full Name _____

Child's Address _____

Home Phone Number _____

Mother's cell phone number _____

Father's cell phone number _____

Mother's Work Phone Number _____

Father's Work Phone Number _____

Any known allergies or medical conditions of child:

Medical Insurance Information

Name Company _____

Name of Member _____

Policy Number _____

Group Number _____

Phone Number _____

Signature of Mother _____

Signature of Father _____

Illness Policy

PARENTS AGREE TO KEEP THEIR CHILD/CHILDREN AT HOME OR SEEK ALTERNATE CARE ARRANGEMENTS FOR THE FOLLOWING CONDITIONS:

- Pain – any complaints of unexplained or undiagnosed pain
- Fever (100 F /38.3 C or higher)
- Sore throat or trouble swallowing
- Headache or stiff neck
- Unexplained diarrhea or loose stool combined with nausea, vomiting or abdominal cramps. The child will be kept at home until all symptoms have stopped.
- Nausea or vomiting
- Sever itching of body and scalp
- Known or suspected communicable diseases.

IT IS REQUIRED TO KEEP (OR TAKE) A CHILD HOME WHEN THE CHILD:

- Is not well enough to take part in the activities at the daycare
- Is suffering from one or more of the above symptoms

ULTIMATELY THE CARE OF THE CHILD IS THE PARENT'S RESPONSIBILITY

Parents will inform the family child care provider within 24 hours of a diagnosis of a serious illness or contagious disease of a communicable nature in the family. This is to protect my family and the other families who attend the family child care home. Failure to do so is grounds for immediate termination of care.

Parents agree that a child will be symptom free, without the aid of symptom reducing medications such as Motrin, Tylenol, etc. for a full 24 hours prior to returning to family child care. We reserve the right to ask for a note from your family doctor, depending on the illness/disease.

MEDICATIONS:

Prescription medications will only be given to a child in care with the following conditions:

Parent gives written permission to the caregiver, with full instructions as to dosage, and times to administer medication.

- Parent must give first dose of any medication
- All prescribed medications must have the child's name on the prescription bottle.
- Non-prescription medications will be administered as per recommended dosages on medicine bottle.

CARE OF A SICK CHILD AND NOTIFICATION OF PARENTS

When a child becomes ill, I will make the child comfortable in a quiet place where he/she can rest and will be closely supervised

Parents will be notified immediately and agree to begin making alternate work arrangements or arrangements for alternate care.

If your child is seriously ill, you or an alternate must come for the child **IMMEDIATELY**.
If I cannot reach a parent, I will call an emergency contact listed on the registration form or the child's doctor
may be contacted depending on the seriousness of the illness.

I _____ parent of _____

Hereby agree to the terms of the illness policy of Family Child Care Provider _____

_____.

Signature _____ Date _____

MEDICATION LOG – PARENTS AUTHORIZATION

I hereby authorized, family child care provider _____ to administer

Name of medication _____ at _____

In the amount of _____ to be administered

_____ to _____
 orally, topically, etc Child's name

on the following dates _____

 Parents or Guardians Name Date

Name of Medication	Amount of Dosage	Method	Date	Time	Initials

This record shall be maintained for six (6) months.

For six (6) months.

FIELD TRIP/WALKS/TRANSPORTATION PERMISSION

Date _____

I/We hereby give _____ permission to take my/our

Child _____ off the premises and on excursions that will

Take place during regular childcare hours.

I understand that I will be notified of any such trips beforehand, that trips

Will be supervised and that all precautions will be made for the safety and well-being of all the children.

I/We also understand that Family Child Care Provider _____ will not be

Liable for any accident or injury.

Consent is for normal activities unless indicated below- the following activities

May occur during the course of the day at the Family Child Care Provider's Home.

Please initial those activities your child has permission to participate in:

_____ Ride in provider's car only

provider must have valid license, registration, insurance and car seats/booster seats/infant carrier)

_____ Go for walks

_____ Go to a park

_____ Go on field trips

Are there any other activities in which your child should not participate? _____

Mother's Signature _____

Father's Signature _____

Date _____

I hereby give permission for:
To pick up my child/ren:
From the home of my family day care provider:
Reason:
Date (s):
Time:
Parent's Signature:

I hereby give permission for:
To pick up my child/ren:
From the home of my family day care provider:
Reason:
Date (s):
Time:
Parent's Signature:

TELL ME ABOUT YOUR CHILD

Child's Name: _____ Birth Date _____

Has your child had previous child care placement? (Select one) YES NO

Where was your child enrolled? _____

If no previous child care experience, has your child been exposed to other children often? Please specify:

Have you ever left your child with a caregiver, babysitter? YES NO

How did he/she react when you left? _____

What is your child's temperament? Are they easy going, hard to please, demanding, aggressive, etc.

What do you expect from your Family Child Care Provider?

Would there be any restrictions to play or activities?

Age your child began to: Sit _____, Crawl _____, Walking _____

Age your child began to: Talk _____ any difficulties with speech? Yes No

If yes to above question, please specify:

Have you made any special arrangement for child's care during illness? Yes or No

Please specify: _____

What is your child's favorite food? _____

What food does your child dislike? _____

Does your child eat with a spoon _____ fork _____ hands _____ ? (check all that apply)

Can your child be relied upon to indicate bathroom wishes? _____

Does your child have any fears related with toileting? _____

Does your child have any "accidents"? _____

What words does your child use for: Bowel movements _____ urination _____

What words does your child use for describing his private parts? _____

Is your child afraid of the dark? _____

What time does your child awaken? _____

What time does your child go to sleep at night? _____

Do they sleep through the night? _____

Do they sleep through the night? _____

Does your child sleep in a bed or crib, other? _____

Does your sleep alone or with someone else? _____

Are there any siblings? Please name them and specify ages and gender.

Name _____ age _____ gender _____

Name _____ age _____ gender _____

Name _____ age _____ gender _____

Has your child had experience playing with other children? _____

Please give a brief description of your child's disposition. Is he friendly by nature, aggressive, shy, withdrawn, imaginative, demanding? Etc. _____

How does your child show his/her feelings? _____

When afraid: _____

When happy: _____

When angry: _____

When intolerant: _____

What forms of discipline are most often used in child's home? _____

How does your child feel about daycare and being left by his/her mommy/daddy? _____

Are there any recent traumatic situations the child has been exposed to such as a death in the family, divorce, new sibling etc? _____

What language (s) are spoken at home? _____

Does your child have any security objects such as a blankie, binkie, bottle, toy etc? _____

How does your child behave when he is sick? _____

How is your child most easily settled when upset or afraid? _____

What are your child's favorite activities, toys, books, or games? _____

Are there any other comments or information you would like to let know about? _____

Parents Signature: _____ Parents Signature: _____

UNIVERSAL CHILD HEALTH RECORD

*Endorsed by: American Academy of Pediatrics, New Jersey Chapter
New Jersey Academy of Family Physicians
New Jersey Department of Health and Senior Services*

SECTION I - TO BE COMPLETED BY PARENT(S)			
Child's Name (Last) _____ (First) _____		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth _____
Does Child Have Health Insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No		If Yes, Name of Child's Health Insurance Carrier _____	
Parent/Guardian Name _____		Home Telephone Number _____	Work Telephone/Cell Phone Number _____
Parent/Guardian Name _____		Home Telephone Number _____	Work Telephone/Cell Phone Number _____
<i>I give my consent for my child's Health Care Provider and Child Care Provider/School Nurse to discuss the information on this form.</i>			
Signature/Date _____			This form may be released to WIC. <input type="checkbox"/> Yes <input type="checkbox"/> No

SECTION II - TO BE COMPLETED BY HEALTH CARE PROVIDER			
Date of Physical Examination: _____		Results of physical examination normal? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Abnormalities Noted:	Weight (must be taken within 30 days for WIC)		_____
	Height (must be taken within 30 days for WIC)		_____
	Head Circumference (if <2 Years)		_____
	Blood Pressure (if ≥3 Years)		_____

IMMUNIZATIONS	<input type="checkbox"/> Immunization Record Attached <input type="checkbox"/> Date Next Immunization Due: _____
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MEDICAL CONDITIONS		
Chronic Medical Conditions/Related Surgeries • List medical conditions/ongoing surgical concerns:	<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached	Comments _____
Medications/Treatments • List medications/treatments:	<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached	Comments _____
Limitations to Physical Activity • List limitations/special considerations:	<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached	Comments _____
Special Equipment Needs • List items necessary for daily activities	<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached	Comments _____
Allergies/Sensitivities • List allergies:	<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached	Comments _____
Special Diet/Vitamin & Mineral Supplements • List dietary specifications:	<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached	Comments _____
Behavioral Issues/Mental Health Diagnosis • List behavioral/mental health issues/concerns:	<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached	Comments _____
Emergency Plans • List emergency plan that might be needed and the sign/symptoms to watch for:	<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached	Comments _____

PREVENTIVE HEALTH SCREENINGS					
Type Screening	Date Performed	Record Value	Type Screening	Date Performed	Note if Abnormal
Hgb/Hct			Hearing		
Lead: <input type="checkbox"/> Capillary <input type="checkbox"/> Venous			Vision		
TB (mm of Induration)			Dental		
Other:			Developmental		
Other:			Scoliosis		

<input type="checkbox"/> <i>I have examined the above student and reviewed his/her health history. It is my opinion that he/she is medically cleared to participate fully in all child care/school activities, including physical education and competitive contact sports, unless noted above.</i>	
Name of Health Care Provider (Print) _____	Health Care Provider Stamp: _____
Signature/Date _____	